

**NOTES****Recovery Program Planning Meeting – Values, Principles and Population Served  
Secure Recovery Residence (SRR)  
Friday, June 12, 2009--- 9:30 a.m. to 12:30 p.m.  
Corrections Chapel Conference Room**

**Persons Present --** Bill McMains facilitated the meeting. The following individuals were present. At various times some people left and returned to the meeting: Elliott Benay, Patrick Kinner, Jay Batra and Tom Simpatico from VSH; Jean New, Consumer; JoAnna Cole, NAMI-VT; Trish Singer, Michael Hartman, Beth Tanzman, Judy Rosenstreich, Bill McMains and Norma Wasko from DMH; Rep. Anne Donahue.

**Purpose of meeting:** To discuss recovery program characteristics that will impact architectural design; to develop concepts of clinical programming sufficient to develop Certificate of Need application.

**Desired outcome of this meeting:**

- Understand what we want program to be
- Not attempt to reach decisions today
- Want to understand ideas, understand different positions
- Difference of opinion okay
- Want to know if something absolutely won't work

**Content of meeting:** First three items on agenda

- Values & Principles
- Population Needs
- Program Characteristics

Framed as:

- What we hope to accomplish
- Context
- Questions

**Context**

- Capital bill approved planning for CON for Secure Recovery Residence
- Process usually takes 6 – 15 months; looking at opening (SRR) 2012
- First steps
  - Create CON application for building design and programming, describe place in system of care, staffing, cost in sufficient detail to address CON planning requirements; a series of meetings over the summer are designed to accomplish this objective.
  - Some pieces of the long term care system to replace VSH are already in place. The SRR would join Second Spring, MeadowView as long term care rehabilitation programs. Need to develop supported nursing home care, but not as function of SRR. Overall idea is to keep people who in non-acute situation out of acute care programs
  - Want input from many sources to be sure we have concepts right. This is different from detailed design for implementation. Process is open, want to consider as many new and different ideas as possible. We will be bringing content from prior focus group meetings (with consumers, patients, clinical staff from VSH and the Community) forward into the design process to be part of final design.

**Principles and Values**

-Prior work of Care Management System working group addressed movement of people between and across programs, one of which will be the SRR.

-Are the concerns, items for the agenda all here?

-Want to discuss smoking at some point.

-Want to talk somewhere about some kind of exercise facility.

-Want to address somewhere relationship between gay and straight folks.

-Clinical sub-groups are missing who have no other place in system as described so far - have not been identified – has program implications.

-Legal issues and implications of legal issues for different programs & groups

-SRR programming should reflect commitment to recovery model for all individuals.

### **Values & Principles sources:**

Hand-outs reflect recovery values from national organizational perspective. One page summary indicates overlap. These are also consistent with the recovery values in the Care Management System planning document on moving clients through the system of care (handout). Want to define values & principles that builders of SRR will follow.

-Should incorporate values formulated in earlier Futures planning documents. Compare to the National formulations; distribute, incorporate into planning documents. Want a consolidated, clear statement of principles & values so definition of recovery is clear, well-understood as applied in SRR planning.

### **Comments about values and principles documents:**

-No professional support indicated in these formulations

-Individual is responsible for own recovery; professionals are there to assist

-Recovery principles have legal overlay that may conflict

-how to define responsibility for own recovery with court ordered treatment

-being free from coercion not necessarily inconsistent with involuntary treatment

-Within “coercive” environment can enhance empowerment, decision-making and fundamental rights; sticking point is “parity” in decision-making with court orders.

-None of the principles apply 100% of time

-Within context of involuntary situation there can be parity of decision making in some places; but not all decisions; parity means all decisions.

-Two definitions of parity here

-Fundamental rights and decision-making vs parity of decision-making need to be worked out in SRR programming

-This is a process: as people move forward in recovery they attain more parity

-Parity of decision-making has to be strong value/principle and that when provider decision overrides that of consumer it is understood as specific to the situation (an exception) to the value; does not become a rule of thumb.

-Principles from New Freedom Report are very, very good

### **Consideration of Clinical Focus Group Values and Principles Document (#4)**

Comments:

**-ADD CONTENT ON** “health care system and individual’s overall health” TO integration and cohesiveness of treatment within facility.

-Need to integrate all values and principles from all sources.

- Need to look at integration of services across facilities.
- Important that individual have own integrated, coherent plan of care that is consistent across programs and systems of care.
- The first and second bullet on values are same (respect); consolidate.
- Likewise 3<sup>rd</sup> and 4<sup>th</sup> bullets.
- ADD bullet on integration of health care -two communities: the greater health care community, and the local geographic community.

## BREAK

### **Population Served by SRR – How Proposed Population was Determined**

Bill McMains provided background on how SRR population was defined:

Initial definition based on distinguishing patients at VSH who needed acute care, and would later leave VSH, from those who reside there. Reviewed 3 years' population data. Acute care population tended to use 25 – 30 beds at any given time. Some growth in Admissions during this period. About 60-70% discharged within 30 days. Asked who no longer needs hospital care:

- Answer: When medical interventions were no longer primary treatment--- i.e., symptoms were stabilized. At this point individuals moved into residential care. New building and program should reflect this. Programming in SRR would have medical interventions as support service. Primary method of care would be psycho-social programming.
- There are levels of required residential care:

-One level = Second Spring.

-Concept of MeadowView for people who required staff secure programming. That is, use staff to provide security rather than locked doors. Otherwise program between two facilities remains pretty much the same.

-Population left at VSH are the individuals with high risk behaviors.

-DMH convened a clinical focus group to further identify this cohort of patients at VSH. This group is what we have for the SRR population. Presents a huge challenge since the range of individuals is so wide.

### **Comments:**

-Don't want to get rid of medical services for this population. No. Medical management is still present, but secondary. Psychosocial programming is primary clinical approach.

-The definition of the population will shift as process of care brings new individuals into the system. Will we have more people who will be coming from Corrections? No. This model is designed to serve people from VSH.

-Clinical characteristics, diagnostic profile, needs shift over time. Could basically count at any given time 15 people, often quite different, who no longer required medical care as the primary service and whose behavior is so dys-regulated that they cannot be somewhere else. Level of risk too high for any other program to manage outside of the state hospital.

### **The Document (#5) Population Served attempts to formulate an initial description of this group.**

**Comments:**

- Nothing in this document talks about how this population is different from other populations. Same language could describe populations at Second Spring and MeadowView.
- Need to **ADD**: And can not be served in a less restrictive environment. Also need to spell out why: e.g., Traumatic Brain Injury, elderly, etc. spell out the range of issues
- One of the challenges of this program is that it has not been done before.
- Question how far can we stretch (e.g., Nursing Home care).

This document needs to capture just how wide these differences are.

- Need to ADD dangererousness – high risk – to self and others. If they don't rise to this level should not be in a locked facility.
- This is final functional common pathway: One cut for defining group would be expectation to improve? People who could not be expected to function at a higher level and move to less intensive modalities later on would not be included?
- Challenge: Issue is we have the people. Can we create a program that fits the people who are here, rather than selecting people for a pre-defined program. Don't have option of selecting people served. **ADD**: "Program is expected to keep facing he challenges presented by the population."

- Need to specify who decides who comes into the program
- Primary diagnosis is a key.
- This is a departure from capturing people by defining out those who do not have severe co-occurring mental illness. Goes to need for system to develop resources and options for the people who would not be admitted to the SRR.
- However, program has to deal with needs of the VSH. BUT is not in this document. Needs to say this. Context of on-going pressure to develop the other programs is necessary.

**-Why the Working Assumption that we develop this program here?**

- It's a question of scale and money in a small, rural state.
- The choice is develop a new program that meets needs of everyone.
- Diagnosis gets in the way. Need to talk about functional capability. Should work for most folks. Perhaps not for some people with TBI, some people with mental retardation. Get in trouble if we screen by diagnosis. If we screen by functional analysis may get there.
- It's difficult. Need to play with models in other realms, see if they fit. E.g., sub-acute rehab; may fit. May not. Good idea to group functionally. But how do we measure improvement, outcomes? Multiple commonalities but also individuals will have very different capacities. Very hard to program for the differences.
- Can't you design a program where the consumer is involved in every aspect of care? So individuals set goals, during day goes to group, during day work on their individual plan for recovery, at end of day in group review their movement toward their goal. Put patient in charge of what is working, not working.
- Individualistic approach is essential. Groups can help. The question is how to get that support in environment where people have very different experiences. Hard to meld the individual approach with the group approach. This may have to do with such things as private and public spaces.
- We must be wlling to include almost anyone who cannot be someplace else unless programming requirements drive us to the conclusion that we can't stretch this program to cover that need: e.g., nursing home required programming; want to try to cover all, be driven to conclusion when we exclude a descriptive group. Then work to get it developed elsewhere.

-Need to acknowledge that any hospital care that replaces VSH or state run inpatient program is controlled by physician privileges and by need for discharge when inpatient care no longer needed. This is a physician hospital decision, not a VSH decision. We don't control this. Represents another group who have unmet needs. There are 4 such groups:

1. First group have challenges that are legal (change legal system and judiciary) that is people who are in need of a forensic evaluation, but not appropriate for inpatient or for a less secure setting. This group is not currently identified to be served. Judiciary has current authority to order them in. Don't impact general hospitals.
2. Second group are criminal commitments: found not guilty and criminally committed. Again not appropriate for inpatient level care. Need secure setting.
3. Third group are inmates who receives inpatient care, ready for discharge, but inadequate Corrections program to meet clinical needs. Under DMH/ CON Criteria / Futures Plan these people cannot be sent back to lower level of care in Corrections system. Theoretically SRR is the only program that could potentially meet the need, others not yet identified
4. Fourth group can no longer benefit from inpatient care because active treatment available has been maxed out due to medication refusal AND they are either pending an involuntary medication order hearing and still need containment, or the court has denied a request for order for involuntary medication

-The first three categories were included in the initial formulation of the SRR population. -Even group 3?

-Some are. Those for whom it was judged they could not receive adequate care in prison. Legal status not relevant. It is the clinical care needs that matter.

-This formulation only addresses current not unmet need.

- But current law mandates that uncounted Group 3 cannot be returned to Corrections.

-This facility is not being built to meet future needs. There will be need for new resources.

-But day one there will be more current need.

-VSH does not currently take all the people who meet this criteria. How can we plan a system without acknowledging this Corrections group? CON will not be granted.

-Could we do a placeholder for future planning.

-No.

-What is the solution?

-Don't know what the solution is. We have expanded the Futures Plan.

-The Legislature / CON is saying serve more people but don't expand the resources.

-The point is acknowledged.

-What about general hospital option to provide involuntary meds?

-Assumed that involuntary meds will be part of the SRR

    This reality needs to be said.

-Will require change of law to permit SRR to do this. Does not fit current criteria.

-How do you expect to build a hospital and an SRR and additional SRRs given current economic context?

-There are other options --- the inpatient facilities could be paid at reimbursement rate at "containment" when not eligible for federal reimbursement because not receiving active treatment.

## **Program Characteristics (Document #6)**

### Comments

-Goals are great.

-There will be a very wide range of lengths of stay. Program should focus on quality of life today. Not just when I get out of here. Need to have a goal around this. ADD GOAL

That encompasses all the things that improve current quality of life over their stay, including health, overall wellness and personal satisfaction and enjoyment.

-Goals of individual plans should be evaluated. People should be able to change their goals. Have follow-up program when they leave to help maintain their successes and gains into next environment.

-4<sup>th</sup> bullet applies to all. Need also a goal to identify need to provide appropriate environments and programming for longer term residents versus short and intermediate lengths of stay. ADD GOAL. Needs to match where people are in their recovery (short and intermediate and longer term groups differently) Idea here of therapeutic milieu.

-Need goal to help people reconnect to their long term relationships, i.e., friends, family. To build these back. ADD GOAL This in addition to building back local community networks.

### **NOTE: GOALS SHOULD CAPTURE ALL THE IMPORTANT VALUES**

-Note: clinical programming should be based on individual resident's needs

-Basic programming approach is based on Positive Behavioral Supports

- PBS provides a way to address the tension between a locked secure environment that is recovery oriented. Fits with trauma informed approach.

-Should provide reference materials for people to read on this. WILL PROVIDE

-Remember that people need specifics within the positive generalities: e.g., "Walking is good." Use visual as well as verbal messages / signs

-If we are working a program that is to be continually analyzed in a learning environment that rigorously evaluates programs, need the architectural design to support this (e.g., include place for staff access to computers)

-Want use of acquired skills in current environment. For example, residents perform useful roles within the environment. Also bring outside community skill learning brought inside. E.g., Current resident has a contract to supply the menu designs, envelope labeling ---- actual employment services to the community. Can include services needed inside the SRR

-Want to develop programming that introduces community skill building AND INCLUDE IN THE GOALS

-Do we want to introduce the concept of the work ordered day? Do we want the expectation set that people will be involved in some kind of gainful activity.

-Matches the architectural design of moving from residence to work, from private to public spaces, with different activities --- educational, occupational, accordingly --- during day.

-Need the concept of the home-ordered day, e.g., leisure time, cooking, household tasks and also free --- down time. All of these involve learning.

Let's be sure to include computer lab in the architectural design to support this approach

**-Key concept: There is no part of the day that is not part of the learning experience.** This is different from current ideas about blocks of programming. Relates to the idea of the rhythm of the day.

-Supported employment should include meaningful activities as a volunteer.

-Need to connect people who are ready to move out of program with skills and desire to work to state benefits counselors to clarify relationship of earned income hours and benefits.

### **Collaborative Problem-Solving**

-Want to see some of the studies on this that relate to the adult psychiatric population. STAFF WILL PROVIDE

-The goals and values of the Seclusion and Restraint grant will apply.

-Cognitive mindfulness are part of the cognitive behavioral strategies.

### **Additional Comments:**

- Supportive environment needs to support staff as well as patients.
- Need to explore and develop best ways to introduce and sustain power of learning among clinicians who must address the challenge of the many differential programming needs of the population
- Need to extend concept of self empowerment to processes of involuntary medication. Need to figure out how to develop this. **RELATES TO GOAL:** Develop people's self-efficacy in voluntary choices. (There are tool kits)
  - Add family support under last bullet of case management planning.
  - Need to address smoking in design phase
  - Supported employment will be discussed further into the program planning process
  - Will discuss roles of peers/ family members / community members at Sept Recovery Program planning meeting

**Next Meeting –June 25-- 10:00 to 1:00 in the Appalachian Gap Room, Osgood building, Waterbury ---will address:**

- Recovery strategies
- Core Clinical Strategies
- Environmental Design
- Emergency Procedures

DMH will send out the link to session agenda and materials on the DMH web site by e-mail before the next meeting.